PUBLIC HEALTH COUNCIL

Meeting of the Public Health Council, Tuesday, October 29, 2002, 10:00 a.m., Massachusetts Department of Public Health, 250 Washington Street, Boston, Massachusetts. Public Health Council Members present were: Dr. Howard Koh (Chairman), Ms. Phyllis Cudmore, Mr. Manthala George, Jr., Ms. Maureen Pompeo, Mr. Albert Sherman, Ms. Janet Slemenda, Dr. Thomas Sterne, and Dr. Martin Williams. Absent was Ms. Shane Kearney Masaschi. Also in attendance was Attorney Donna Levin, General Counsel.

****

Chairman Koh announced that notices of the meeting had been filed with the Secretary of the Commonwealth and the Executive Office of Administration and Finance, in accordance with the Massachusetts General Laws, Chapter 30A, Section 11A ½. In addition, Dr. Koh welcomed Albert Sherman back to the Council. Mr. Sherman has already served 14 years as a Public Health Council Member and has just been re-appointed for a six year term.

****

The following members of the staff appeared before the Council to discuss and advise on matters pertaining to their particular interests: Dr. Teresa Anderson, M.S.W., Ph.D, Director, Office of Statistics and Evaluation, Bureau of Substance Abuse Services; Ms. Suzanne Condon, Assistant Commissioner, Bureau of Environmental Health; Mr. Howard Wensley, Director, Division of Community Sanitation; Ms. Joyce James, Director, Mr. Jere Page, Senior Analyst, Ms. Joan Gorga, Program Analyst, Determination of Need Program; and Attorney Edward Sullivan, Deputy General Counsel, Office of the General Counsel.

PERSONNEL ACTIONS:

In letters dated October 3, 2002, Katherine Domoto, M.D., Associate Executive Director for Medicine, Tewksbury Hospital, Tewksbury, recommended approval of the appointments and reappointments to the various medical staff of Tewksbury Hospital. Supporting documentation of the appointees' qualifications accompanied the recommendation. After consideration of the appointees' qualifications, upon motion made and duly seconded, it was voted (unanimously): That, in accordance with the recommendation of the Associate Executive Director for Medicine of Tewksbury Hospital, under the authority of the Massachusetts General Laws, Chapter 17, Section 6, the following appointments and reappointments to the various medical staffs of Tewksbury Hospital be approved for a period of two years beginning October 1, 2002 to October 1, 2004:

APPOINTMENTS	STATUS/SPECIALTY	MEDICAL LICENSE NO.
Naaznin Lokhandwala, M.D.	Provisional Affiliate Internal Medicine	157742
Justin Mohatt, M.D.	Provisional Affiliate Psychiatry	214886
Beatrice Szeto, M.D.	Provisional Active Psychiatry	210162
Melissa Wheelock, M.D.	Provisional Affiliate Psychiatry	212544

REAPPOINTMENTS	STATUS/SPECIALTY	MEDICAL LICENSE NO.
David Berman, M.D.	Consultant Staff Urology	51207
Herman Haimovici, M.D.	Consultant Staff Radiology	29566
Chih Yeh, M.D.	Affiliate Staff Internal Medicine	80819

In a letter dated October 7, 2002, Paul D. Romary, Executive Director, Lemuel Shattuck Hospital, Jamaica Plain, recommended approval of initial appointments and reappointments to the medical and allied health staffs of Lemuel Shattuck Hospital. Supporting documentation of the appointees' qualifications accompanied the recommendation. After consideration of the appointees' qualifications, upon motion made and duly seconded, it was voted (unanimously): That, in accordance with the recommendation of the Executive Director of Lemuel Shattuck Hospital, under the authority of the Massachusetts General Laws, Chapter 17, Section 6, the initial appointments and reappointments to the medical and allied health staffs of Lemuel Shattuck Hospital be approved as follows:

APPOINTMENTS	STATUS/SPECIALTY	MEDICAL LICENSE NO.
Ari Berman, M.D.	Consultant/Internal Medicine	213491
John Cadigan, M.D.	Active/Cardiology	51090
Eugene Lam, M.D.	Consultant/Internal Medicine	215897
Daniel Oates, M.D.	Consultant/Internal Medicine	215230
Frank Schembri, M.D.	Consultant/Internal Medicine	215628
Simran Kaur Singh, M.D.	Consultant/Internal Medicine	215123
Sunil Shroff, M.D.	Consultant/Internal Medicine	215812

REAPPOINTMENTS	**STATUS/SPECIALTY**	**MEDICAL LICENSE NO.**
Nicolaos Athienites, M.D.	Consultant/Internal Medicine Nephrology	73425
Salah Alrakawi, M.D.	Active/Internal Medicine	154525
Katherine McGown, M.D.	Active/Internal Medicine Infectious Disease	42007
Raymond Murphy, M.D.	Consultant/Pulmonary Medicine	28072
Rochelle Scheib, M.D.	Active/Internal Medicine Medicine Oncology	58167
Bradford Navia, M.D.	Active/Neurology	56112
Sheida Sharifi, M.D.	Consultant/Pathology	155808
Marshal Folstein, M.D.	Consultant/Psychiatry	77321
Ernst Manigat, M.D.	Consultant/Psychiatry	157166
Elliot Pittel, M.D.	Consultant/Psychiatry	53914
Peter Barrett, M.D.	Consultant/Radiology	31530
Rafeeque Bhadelia, M.D.	Consultant/Radiology	78973
Annekathryn Goodman, M.D.	Consultant/Gynecology	53787
John Jameson, M.D.	Consultant/ENT	72421
Olarewaju Oladipo, M.D.	Active/Orthopedic Surgery	151848

ALLIED HEALTH PROFESSIONALS REAPPOINTMENT

Katherine Keefe, PA	Internal Medicine	228
Gail Polli, RNCS	Psychiatry	146723

Lemuel Shattuck Hospital also indicated the following resignations: Astride Desrosiers, M.D. – Department of Psychiatry; Jennifer Fyler, M.D. – Department of Psychiatry; Alexey Makogonov, M.D., Department of Medicine; Richard Patten, M.D., Department of Medicine.

In a letter dated October 8, 2002, Blake Molleur, Executive Director, Western Massachusetts Hospital, Westfield, recommended approval of the appointment of Claude Borowsky, M.D. to the consulting medical staff of Western Massachusetts Hospital. Supporting documentation of the appointee's qualifications accompanied the recommendation. After consideration of the appointee's qualifications, upon motion made and duly seconded, it was voted (unanimously): That, in accordance with the recommendation of the Executive Director of Western Massachusetts Hospital, under the authority of the Massachusetts General Laws, Chapter 17, Section 6, the appointment of Claude Borowsky, M.D. to the consulting medical staff of Western Massachusetts Hospital be approved as follows:

APPOINTMENT	STATUS/SPECIALTY	MEDICAL LICENSE NO.
Claude Borowsky, M.D.	Consultant/Physiatry	154635

STAFF PRESENTATIONS:

"MASSACHUSETTS YOUTH HEALTH SURVEY 2002: ALCOHOL, DRUG AND CIGARETTE USE AMONG SCHOOL AGE CHILDREN," by Teresa Anderson, M.S.W., Ph.D., Director, Office of Statistics and Evaluation, Bureau of Substance Abuse Services:

Dr. Teresa Anderson, Director, Office of Statistics and Evaluation, Bureau of Substance Abuse Services, presented the Mass. Youth Health Survey 2002 to the Council. She said in part, "…We are very pleased to be able to show you an effort today that is really just a little over a year old. Last year, we began an endeavor with the Department of Education to be able to develop annual estimates of alcohol, tobacco and other drug use across the high schools and for us to have estimates in the middle schools. What you will see today is the first preliminary findings of this new effort….We also worked with CDC which was a first effort for us. This project represents a departure from the triennial school survey, which I showed to you about two years ago. This is a new effort. Many of the questions are the same as were used on the triennial school survey, but many are different. A step forward for us in working with CDC is that this project satisfies Massachusetts requirement for a youth tobacco survey, and what we are going to focus on this morning includes tobacco, as well as other drugs. We surveyed three thousand students in grades six through twelve, which allows us to make estimates for the state for middle school and for high school students (collected data from 50 middle and 50 high schools from March 2002 to June 2002). Participation in the survey by the students was voluntary. The survey was administered by professionals from JSI Research and Training. The teachers were not the administrators of the survey and the data was removed from the school on the same day that the survey was conducted and sent to the CDC." Among the survey highlights:

- The most commonly reported age of first alcohol use increased to 11-12 years in 2002 from 9-10 years in 1999.
- Current alcohol use by middle school students decreased 15%, from 24.3% to 20.6% since 1999.
- Current alcohol use by high school students decreased 13.5% from 58% to 50% since 1999.
- The most commonly reported illicit drug in middle school and high school was marijuana followed by cocaine/crack.
- Among high school students, marijuana use declined from 29.6% to 25.4%

- Since 1999, middle school students reported a 13% decline in current cigarette use from 9.2% to 8% and high school students reported a 29.7% decline from 30% to 21%.

In closing, Dr. Anderson said, "We will be completing analysis on this data. We have only had it in house for about six weeks now, and we have a lot more to analyze. We have much more data that looks at other school health issues in addition to alcohol, tobacco and other drugs…"
Dr. Koh, Chairman, added, "…Your report offers many insights into one of the most troubling issues of our time, and that is substance abuse in kids. We know that alcohol, tobacco and other drugs lure our children with promises of glamour and escape, but these are false promises and substance abuse only drives kids deeper into a world complicated by issues like violence and crime, truancy, depression, HIV, and the list goes on, unfortunately. It is fair to say that substance abuse enters our children's lives at a time of greatest vulnerability, and we are very concerned about kids starting at a very young age because studies show, particulary for alchohol, the younger a person starts using alcohol, the more likely that person will have lifetime problems with alcohol. Your results show many important findings. The good news is that current alcohol use is declining in middle school and high school students and there are striking declines in cigarette use. We have slight declines in marijuana use in high school students, and some slight declines in club drug use in high school students. On the other hand, we are very concerned about rising rates of cocaine and crack, through both middle school and high school students…I think we all agree that the only solution to this is a continued emphasis on prevention. It needs the involvement of all young people, all parents, all teachers and especially all communities, and we have had some progress lately in terms of community-based prevention models. Our new Regional Centers for Healthy Communities are tackling these issues from a variety of angles…"

A discussion followed. Council Member Sterne noted for the record, that he is concerned, as a community health center director, that the tobacco cessation program funds, funded in part by the legal settlements, have evaporated."

NO VOTE/INFORMATION ONLY

"ENVIRONMENTAL HEALTH TRACKING IN MASSACHUSETTS", by Suzanne Condon, Assistant Commissioner for the Bureau of Environmental Health:

Ms. Suzanne Condon presented information on the Centers for Disease Control's (CDC) new initiative to have the states develop a standards-based environmental public health tracking network. She said in part, "Essentially, what this will enable us to do is to develop new health databases and link them electronically with existing environmental databases, largely developed by environmental regulatory groups. In 2001, the Environmental Health Commission released a report entitled, 'America's Environmental Health Gap: Why the Country Needs a New Environmental Health Tracking Network.' Among the many conclusions of the Commission was an important one that very clearly stated that environmental health programs across the country lacked the necessary financial resources and infrastructure to adequately respond to the increasing public health concerns over disease prevalence in the environment. I can speak very clearly about this due to the work that has been done by many of the staff that work for me in the Environmental Health Bureau, as they have tried desperately to come up

with unique ways of looking at existing databases and tried to appropriately respond to the demand for public information. Within the last several days, Massachusetts has now become one of the seven state health departments across the country to receive funds to actually implement an Environmental Public Health tracking system. The initial year of funding is about $680,000 dollars, but ultimately, over this first three year period of the demonstration program, Massachusetts will receive approximately 2.4 million dollars. There are 13 other states or local health departments that have received planning grants, focused on a similar type of activity, but they are not at the stage that these other seven states are, with respect to being in a position to actually implement the systems. It does offer us the opportunity to partner with other New England states, and share what we have learned, during their planning process. The ultimate goal being to develop a national system so that we can learn much more in a very quick manner. The three outcomes of interest for those of us working on this effort in Massachusetts are pediatric asthma, systemic lupus arythmatosis, or lupus, and development effects. These outcomes are of interest to Environmental Health researchers based on work that has been done here in Massachusetts, as well as across the country…"

Ms. Condon noted the following facts:

- In 1999, DPH released a report showing that there is a statistically significant higher rate of pediatric asthma in our public school children for children who attended schools with indoor air quality problems, compared to children who attended schools with no indoor air quality problems;

- There is increasing evidence that exposure to sources of petroleum distillates, such as those that might be present at some of our state hazardous waste sites, has been linked to both connective tissue diseases and auto immune disorders, and lupus is the one the Department is focusing on;

- National studies have begun to show a link between mothers exposed to PCBs during pregnancy and subsequent developmental effects in their children later in life;

- The Bureau will be developing a surveillance system for pediatric asthma in concert with the Family and Community Health Bureau, focusing on the 186 communities in the Department's Enhanced School Health Network program;

- This pediatric surveillance system will rely on reporting by the school nurses, instead of using hospital discharge data; this data then will be linked to the Bureau's indoor air quality data;

- Information will be shared with the Department's Office of Occupational Health, which has won funding to study work place exposures of asthma among public school teachers;

- The Bureau will focus on lupus in the City of Boston since the prevalence of lupus is higher among African American females, Latino and Asian women using hospital discharge and billing information. The Bureau has been focusing their study in the neighborhoods of Greater Roxbury and South Boston;

- The Bureau will work with the Department of Environmental Protection, providing that Bureau with a staff person to develop the DEP data bases;

- The Bureau will study PCB exposures on the Housatonic River area in Berkshire County and New Bedford Harbor as it relates to developmental effects among three to ten year old children through existing databases in our department's Early Intervention Program and also working with the Department of Education;

- The Developmental data will be linked with the PCB exposure data entered into a geographic information system developed by our Environmental Toxicology Program, which will indicate to staff if children with developmental problems are living in areas with serious PCB contamination;

- The Bureau will be working with researchers from UMass Medical Center on a variety of projects. UMMC maintains databases with information that may be useful to the Department in identifying the role of the environment in reproductive effects.

Chairman Koh, added, "This is outstanding news, and let me just publicly thank you for your leadership here. Environmental Health is an area that desperately needs better data and tracking systems. This grant is truly allowing us to pursue new opportunities in eradicating disparities. Massachusetts is a leader in this regard, and it is because of your work and the work of your colleagues, Deputy Director Steele and Dr. Davis and many others…"

Council Member Cudmore asked if the other states would be collecting the same kind of data so that it can be compared. Assistant Commissioner Condon replied that yes, the grant requires collaboration between the states for that reason.

NO VOTE/INFORMATION ONLY

REQUEST FOR FINAL PROMULGATION OF AMENDMENTS TO 105 CMR 450.000: MINIMUM HEALTH AND SANITATION STANDARDS FOR DYS SECURE RESIDENTIAL FACILITIES:

Mr. Howard Wensley, Director, Division of Community Sanitation, presented the minimum health and sanitation regulations to the Council. Mr. Wensley said in part, "… Since the early 1900s, the Department of Public Health (DPH) pursuant to M.G.L.c.111ss.20, has been authorized to set the health and sanitation standards for secure juvenile detention facilities (secure DYS facilities) under the control of the Department of Youth Services (DYS). In the past, this authority has included the obligation to inspect such facilities at various intervals. For approximately the last 30 years, the Department has inspected these facilities pursuant to its regulations promulgated at 105 CMR 450.000 and reported the results back to DYS. Within the last decade, another state agency, the Office of Child Care Services (OCCS), has also relied exclusively on DPH inspection reports of secure DYS facilities to license these programs. Although 105 CMR 450.000 originally set the requirements for both adult correctional facilties and juvenile facilities, statutory amendments to c.111, ss.20 in the 1970s and

1980s removed the secure DYS facilities from mandatory inspections. In the absence of regulatory authority, the Department's Division of Community Sanitation (DCS) has continued to inspect all secure DYS facilities to ensure that they were adequately maintained. In early 2002, the Department began a review of 105 CMR 450.000 in an effort to update the regulations and check them for legal accuracy. In light of the fact that statutory authority for DPH to inspect secure DYS facilities no longer existed, such references needed to be deleted. At the same time, DYS and DPH wanted to ensure that necessary inspections continued and therefore the agencies are in the process of developing a Memorandum of Understanding that will authorize DPH to continue to inspect secure DYS facilities." The proposed revisions include:

- Amend scope of regulations to limit its applicability to secure DYS facilities only. The facilities regulated in **105 CMR 450.000 et. Seq**. are buildings characterized by locked entrances and exits and other physically restrictive construction intended to prevent a resident from departing without approval of DYS (currently 35 facilities).

- All recommended standards in **450.012 (.300 series**) are being changed from "should" to "shall be" to reflect that all standards must be followed as the result of the amendment of M.G.L.,C.111,ss.21.

- **450.150-450.215**: eliminate subparagraphs that deal with various components of the food service operation, replacing them with the requirement that such facilities meet the standards of 105 CMR 590.000: State Sanitary Code, Chapter X – Minimum Sanitation Standards for Food Establishments. Chapter X contains all of the individual standards that are being stricken in these revisions.

- **450.173:** Prohibit use of tobacco in the entire facility instead of just food-related areas.

- **450.320:** Reduce minimum square footage of a multiple occupancy room from 60 square feet per occupant to 50 square feet. It also sets a standard of 70 square feet for a single occupancy room. This standard will now be the same as required for a sleeping area in any residential building.

- **450.329:** Add language requiring that all asbestos containing material be maintained in a non-friable state and that any asbestos mitigation/remediation work be accomplished in accordance with the regulations of the Departments of Environmental Protection and Labor and Workforce Development.

- **450.600:** Language is added that will allow the commissioner or his/her designee to vary any of these regulations if their strict enforcement would do manifest injustice and provided that any variance would not conflict with the spirit and intent of the regulation as written or any other applicable statute, code or regulation.

Staff noted that a public hearing notice was filed with the Secretary of State and published in the Boston Herald and the Springfield Union. The hearing was held on June 11, 2002 at the State Laboratory

Institute. No one provided oral testimony. Only DYS provided written comments.
Staff noted further that the Department of Youth Services (DYS) submitted two substantive comments. One comment was in response to the proposed requirement at 105 CMR 450.382 "that each facility…have a written and rehearsed plan for fire and emergency evacuation approved by the local fire department." DYS questioned whether the proposed regulation could be enforced, quoting a recent opinion from the Attorney General who concluded, based upon a review of the relevant provisions of M.G.L.c.148, that the provisions of the State Fire Code are not applicable to buildings owned by the Commonwealth. DYS further noted that while most fire departments have continued to inspect DYS owned facilities, there has been at least one fire Department that, after interpreting the Attorney General's opinion "will not inspect or for that matter will probably not approve a fire evacuation plan." As a result of this comment and the Attorney General's opinion, the language in 105 CMR 450.382 was amended to require the facility to submit a plan for fire and emergency evacuation to the local fire department with a request that it review and approve the plan as submitted. The other substantive comment received from DYS concerns the definition of Program Manager…It was noted by DYS that a Program Manager could be a contracted vendor rather than an employee. The definition was expanded to include a contractor serving in the capacity of a Program Director of a DYS Secure Residential Facility.

After consideration, upon motion made and duly seconded, it was voted: (Chairman Koh, Ms. Cudmore, Mr. George, Jr., Ms. Pompeo, Ms. Slemenda, Dr. Sterne, and Dr. Williams in favor; Mr. Sherman not present to vote [Ms. Kearney Masaschi absent] to approve the **Request for Final Promulgation of Amendments to 105 CMR 450.000: Minimum Health and Sanitation Standards for DYS Secure Residential Facilities**; that a copy be forwarded to the Secretary of the Commonwealth; and that a copy be attached and made a part of this record as **Exhibit No. 14,739**.

DETERMINATION OF NEED PROGRAM:

INFORMATIONAL BULLETIN ON ANNUAL ADJUSTMENT TO DoN EXPENDITURE MINIMUMS:

Ms. Joyce James, Director, Determination of Need Program, presented the annual inflation adjusted DoN expenditure minimums required by Determination of Need regulations (M.G.L.c.111,s.25B1/2) to the Council for approval. Staff noted, "Since the U.S. Department of Health and Human Services does not have an appropriate index, the inflation indices used by the DoN Program staff to adjust DoN threshold dollar amounts are: Marshall & Swift for capital costs, DRI/McGraw Hill for operating costs (Standard & Poor's DRI Health Care Cost Review). These indices have been chosen by the Determination of Need Program as an authoritative resource due to their extensive use within the health care industry to determine inflation rates for a number of health care expenditures. While each of the indices has various regional and market sector subtleties and shadings, it is important for ease of administration to use a single inflation factor for capital costs and a single factor for operating costs. Thus, Marshall & Swift's statewide figures are used for the capital cost inflation and the average of DRI/McGraw-Hill hospital and nursing home figures is used as the basis for recalculating inflated operating costs. If usable figures are not available for September 1 of each year, inflation will

necessarily be calculated as of some earlier date. The precise mechanisms for these calculations are set forth in Exhibit A. The newly calculated expenditure minimums are set forth in Exhibit B. These figures are effective September 1, 2002."

After consideration, upon motion made and duly seconded, it was voted: unanimously to approve the **Request for Adoption of the Final Informational Bulletin on Annual Adjustments to DoN Expenditure Minimums, dated October 29, 2002 as follows:**

Annual Adjustments to Determination of Need Expenditure Minimums

Capital Costs Indices (Marshall & Swift):

	September 2001	September 2002
REGION – EAST	1879.8	1923.9
MASSACHUSETTS	1.09	1.11

$$\frac{1923.9}{1879.8} \times \frac{1.11}{1.09} = 1.0422$$

Operating Costs (DRI/McGraw-Hill):

	3rd Quarter 2001	**3rd Quarter 2002**
Skilled Nursing	1.164	1.403
Hospital	1.302	1.344

$$\frac{(1.403 + 1.344)/2}{(1.164 \quad 1.302)} = 1.1188$$

Capital Expenditure

September 1, 2001	Filing Year Beginning September 1, 2002
$531,810[1]	$554,273
$1,063,622[2]	$1,108,548
$9,971,450[3]	$10,392,634

Operating Costs

September 1, 2001	Filing Year Beginning September 1, 2002

[1] Medical, diagnostic or therapeutic equipment for non-acute care facilities and clinics

[2] Total Capital expenditures, including medical, diagnostic or therapeutic equipment, for non-acute cre facilities and clinics

[3] Capital expenditures for acute care hospitals and comprehensive cancer centers, excluding major movable equipment

$582,064[4] $651,209

COMPLIANCE MEMORANDUM:

NOTE: Docket Item 5a – Previously Approved Project No. 1-3501 and Project No. 1-4677 of Western Massachusetts Magnetic Resonance Services, Inc. - Request for Transfer of Site was pulled from the agenda by the applicant; therefore was not heard and no vote was taken by the Council.

PREVIOUSLY APPROVED DoN PROJECT NO. 2-3956 OF HEALTHALLIANCE HOSPITALS – PROGRESS REPORT ON COMPLIANCE WITH CONDITIONS OF APPROVAL FOR TRANSFER OF OWNERSHIP:

Mr. Jere Page, Senior Analyst, Determination of Need Program, presented the HealthAlliance Progress Report to the Council. He said, "I am happy to say that we have reviewed the seventh and hopefully final progress report submitted by Health Alliance regarding the specific conditions of DoN Project Number 2-3956. This was a project originally approved by the Council in 1998, in which Health Alliance merged with the UMass system. In staff's sixth report, presented to the Council on April 23, 2002, staff had determined that HealthAlliance had substantially complied with all 12 conditions of approval, related respectively to statutory free care, emergency services, regional EMS services, financial investment, governance, non-emergency transportation, free care services, interpreter services, mental health, education and outreach, and outreach services…In addition, staff determined further that conditions for the goverance, interpreter conditions and mental health services would require more time for full implementation. We also recommended to the Council in April that further progress reports not be required if it was determined that Health Alliance was in full compliance of all the twelve conditions at the time of this report, and I am happy to say that we have now found them to be in full compliance with all these twelve conditions. For example, since April, regarding governance, HealthAlliance now has a community review process in place to effectively identify and recommend qualified and diverse Board of Trustee candidates, and Health Alliance is now meeting with minority community members regarding the current Board vacancy. With respect to interpreter services, Health Alliance is now committed to maintaining a more visible interpreter service presence at the Burbank Campus…We recommend no further progress reports be required on these fully implemented conditions…" No comments were made by the applicant or the Northern Health Care Coalition.

After consideration, upon motion made and duly seconded, it was voted: (unanimously) to approve Staff's recommendation that **no further HealthAlliance progress reports be required on the fully implemented conditions of approved DoN Project No.2-3956**; and that a copy of the final report be attached and made a part of this record as **Exhibit No. 14, 740.**

[4] Annual operating costs including staffing costs for non-acute care facilities and clinics

CATEGORY 1 PROJECT:

PROJECT APPLICATION NO. 6-4894 OF NORTH SHORE MAGNETIC IMAGING CENTER, INC. TO PROVIDE MOBILE POSITRON EMISSION TOMOGRAPHY (PET) SERVICES AT THREE HOST SITES: BEVERLY HOSPITAL, BEVERLY, SALEM HOSPITAL, SALEM, AND NORTH SHORE CANCER CENTER, PEABODY:

Mr. Jere Page, Senior Analyst, Determination of Need Program, presented Project Application No. 6-4894 to the Council. Mr. Page said, "The North Shore Magnetic Imaging Center proposes to provide mobile positron emission tomography (PET) services at three host sites; Beverly Hospital, Salem Hospital, and the North Shore Cancer Center in Peabody. The service will be provided through an outside vendor who will provide the mobile PET service initially for two and a half days per week, or fifty percent of normal utilization. The recommended MCE is 1.1 million dollars, which is the fair market value of the mobile PET scanner operating at fifty percent utilization, fifty percent of normal utilization. The project was reviewed against the review factors in the DoN guidelines for PET services, and we found that, based on the two and a half day per week schedule, the applicant's projected volume is equivalent to the minimum volume requirements of the guidelines for a full-time PET scanner operating at least five days a week."

Mr. Page continued, "In response to the Community Initiatives Requirement, the applicant has agreed to provide a total of $55,000 dollars over five years to support the Health Community efforts of the North Shore Community Health Network area, which includes the communities of Danvers, Lynn, Lynnfield, Marblehead, Nahant, Peabody, Salem, Saugus and Swampscott. These efforts may include, but are not limited to asthma case coordination, community based interpreter services and the Enlace Program, a program involving networking in the Lynn Hispanic Community. In conclusion, we are recommending approval in part with conditions that are listed on page 10 of the staff summary."

Council Member Slemenda asked staff what she should expect in the future in regards to PET requests – are they expected to proliferate - or is there going to be containment of this service?

Ms. Joyce James, Director, Determination of Need Program responded to Ms. Slemenda. Ms. James said, "It is difficult to determine need projections because of the evolution of the technology, at this point, we look at the capacity of the PET scanner and if an institution is able to project 2500 scans, then we will recommend approval." Ms. James stated that she felt that the process would probably be similar to the MRI -- that the technology will continue to improve so rapidly -- with new applications all the time, making it difficult to develop definite numbers.

Dr. John Oldershaw, Radiologist, Beverly Hospital and Massachusetts General Hospitals, addressed the Council, representing the applicants. He noted, "…I trained here in Boston as a radiologist, have been board certified both in radiology and in nuclear medicine. I remain on the staff of Massachusetts General Hospital as a radiologist and a consultant, and I have presently been appointed the Medical Director for PET Imaging Services for NSMIC, which is before you today seeking approval. The PET imaging technology has in fact been around for some time, but has gained popularity over the last five years because we found applications that would benefit patients. In particular, cancer detection, staging, and diagnosis. It is a metabolic imagining technique. We are looking at actual function of the body. Whereas, with MRI, CAT scans, x-rays, we look at structures, PET scanning allows us to look at the actual metabolic activity of the body and look for abnormal areas of metabolic activity, which are characteristics of cancer. We find this an exciting new technology to apply to existing areas and existing ways of looking at abnormal processes that affect the human body. Having been trained in Boston and having been trained specifically in PET, I understand that there is a very high demand, and an unmet demand presently, for cancer patients that are seeking this type of imaging technique. We hope to introduce this technology on the North Shore, which has a substantial population and has a cancer center, to help alleviate the long waiting times, and to assist these patients in their quest to eliminate and perhaps lead more useful and productive lives, even though they are afflicted…We have very strong ties to the academic community here in Boston, and our hope today is to seek approval for this technology, that we may be able to help patients on the North Shore, and provide them superior services, the same that they receive here in Boston."

After consideration, upon motion made and duly seconded, it was voted: (Chairman Koh, Ms. Cudmore, Mr. George, Jr., Ms. Kearney Masaschi, Ms. Pompeo, Mr. Sherman, Ms. Slemenda, and Dr. Williams; Dr. Sterne recused himself) to approve **Project Application No. 6-4894 of North Shore Magnetic Imaging Center, Inc.,** with a maximum capital expenditure of $1,100,000 (February 2002 dollars) and revised first year operating costs of $883,125 (February 2002 dollars). A summary is attached and made a part of this record as **Exhibit No. 14,741**. As approved, this application provides mobile Positron Emission Tomography (PET) services at three host sites: Beverly Hospital, Beverly, Salem Hospital, Salem, North Shore Cancer Center, Peabody. This Determination is subject to the following conditions of approval:

1. North Shore Magnetic Imaging Center shall accept the maximum capital expenditure of $1,100,000 (February 2002 dollars) as the final cost figure, except for those increases allowed pursuant to 105 CMR 100.751 and 752.

2. North Shore Magnetic Imaging Center shall not consider ability to pay or insurance status in selecting or scheduling patients for PET services.

3. North Shore Magnetic Imaging Center will provide a total of $55,000 (February 2002 dollars) over five years at $11,000 per year to support the health communities efforts of the North Shore Community Health Network Area (CHNA#14). Based on discussions with NSMIC and CHNA #14, these efforts may include, but are not limited to asthma case coordination, community-based interpreter services, and the Enlace Program involving networking in the Lynn Hispanic community.

Funding for this initiative will begin upon project implementation, and notification to the Department's Office of Healthy Communities at least two (2) weeks prior to implementation. The yearly contribution will be sent to a community organization selected by CHNA #14.

4. Unless otherwise approved by the Department, North Shore Magnetic Imaging Center shall provide services only at the sites and the days indicated in this approval. Any request for change in either number of days or specific sites served shall be considered a minor change as provided by 105 CMR 100.752.

Staff's recommendation was based on the following findings:

1. North Shore Magnetic Imaging Center proposes to provide Positron Emission Tomography (PET) services through a mobile PET body scanner at three host sites: Beverly Hospital, Beverly, Salem Hospital, Salem, and the North Shore Cancer Center, Peabody.

2. The project meets the requirements of the health planning process consistent with the Guidelines for Positron Emission Tomography (Guidelines).

3. North Shore Magnetic Imaging Center has demonstrated demand for a mobile PET unit to serve Beverly Hospital, Salem Hospital, and the North Shore Cancer Center, as discussed under the Health Care Requirements factor of the staff summary.

4. The project, with adherence to a certain condition, meets the operational objectives of the guidelines.

5. The project meets the compliance standards of the guidelines.

6. The recommended maximum capital expenditure of $1,100,000 (February 2002 dollars) is reasonable, based on a similar, previously approved project.

7. The recommended operating costs of $883,125 (February 2002 dollars) are reasonable for a freestanding mobile PET service.

8. The project is financially feasible and within the financial capability of the applicant.

9. The project meets the relative merit provisions of the DoN guidelines.

10. The project, with adherence to a certain condition, meets the community health service initiatives of the DoN Regulations.

ALTERNATE PROCESS FOR TRANSFER OF OWNERSHIP APPLICATION: PROJECT APPLICATION NO. 4-3A42 OF NEW ENGLAND MEDICAL CENTER HOSPITALS, INC.

– REQUEST FOR TRANSFER OF OWNERSHIP AND ORIGINAL LICENSURE OF NEW ENGLAND MEDICAL CENTER HOSPITALS, INC.:

Ms. Joan Gorga, Program Analyst, Determination of Need Program, presented Project Application No. 4-3A42 of New England Medical Center Hospitals, Inc. to the Council. Ms. Gorga stated, "The applicant, New England Medical Center Hospitals, Inc., licensee of New England Medical Center, is seeking approval for a transfer of ownership and original licensure of the medical center. The transfer results from a restructuring agreement between NEMC hospitals, New England Medical Center, Lifespan and Lifespan of Massachusetts by which the parties have agreed to change their corporate structure. Under the agreement, Lifespan of Massachusetts would no longer serve as the controlling member and New England Medical Center would become the sole corporate parent of NEMC Hospitals. The Board of Trustees of New England Medical Center has determined that the restructuring of its agreement with Lifespan and Lifespan of Massachusetts is in its best interest due to changing economic conditions and changes in the insurance market. The application was reviewed using the alternative process for change of ownership. The standards apply and include required residence in the applicant's primary service area for a majority of individuals involved in decision making for the facility. They also include no access problems identified by the Division of Medical Assistance, and no violence or fraud provisions. The applicant has agreed to maintain or increase the 2.11 percent of gross patient service revenue allocated to free care, as existed prior to the transfer, which staff is recommending as a condition of approval. The applicant is a licensed facility. A public hearing was requested on the application by a group from New England Medical Center. The hearing was held here on October 18th. Three people attended and Dr. Thomas O'Donnell, President and CEO of New England Medical Center, testified. There were no speakers in opposition to the DoN. In conclusion, staff recommends approval of the application, Project No. 4-3A42. Since there were no comments in opposition to the approval received prior to October 24th, condition no. 2 no longer applies…"

Dr. Thomas O'Donnell, President, New England Medical Center, testified to the Council. Dr. O'Donnell noted in part, "…Ms. Gorga summarized it very nicely, but certainly the Former Speaker of the House stated it best when he said, 'All Politics are Local'. I think this is realization for both our Rhode Island colleagues and New England Medical Center that health care is local and we best return to a locally governed system, a local hospital and I think this will allow us to provide a Massachusetts network relationship with our hospital and also deliver care better to our neighbors in the Asian community of Boston…"

After consideration, upon motion made and duly seconded, it was voted (unanimously): That **Project Application No. 3A42 of New England Medical Center Hospitals, Inc.** be approved, based on staff findings; and that a copy be attached and made a part of this record as **Exhibit No. 14, 742.** As approved, the application provides for transfer of ownership and original licensure. The transfer of ownership and original licensure of NEMC Hospitals results from a restructuring agreement between NEMC Hospitals, NEMC, Lifespan and LOM by which the parties have agreed to change their corporate structure resulting in NEMC becoming the sole corporate parent of NEMC Hospitals. NEMC Hospitals will continue to be the licensee of New England Medical Center Hospital. This

Determination is subject to the following conditions:

1. The Applicant has agreed to maintain or increase, for an indefinite period, the percentage of gross patient service revenue allocated to free care, as defined at M.G.L.c.118G or its successor statute covering uncompensated care, as existed prior to the transfer. The percentage of gross patient service revenue for New England Medical Center allocated to free care shall be 2.11%.

2. The Department's approval shall become final at the close of business on October 29, 2002, provided that, if comments in opposition to the Department's approval or a request for a hearing, pursuant to 105 CMR 100.603 (B) are received prior to the close of business on October 24, 2002, the approval shall not be final and the application shall be considered de novo, at a subsequent meeting of the Council.

Staff's recommendation was based on the following findings: That the application satisfies the requirements for the Alternate Process for Change of Ownership found in 105 CMR 100.600 et seq. Staff further found that the applicant satisfies the standards applied under 100.602 as follows:

A. Individuals residing in the Hospital's health systems area comprise a majority of the individuals responsible for decisions concerning:

   1. approval of borrowings in excess of $500,000;

   2. additions or conversions which constitute substantial change in services;

   3. approval of capital and operating budgets; and

   4. approval of the filing of an application for determination of need.

B. The Applicant had consulted with the Division of Medical Assistance (DMA) concerning the access of medical services to Medicaid recipients at its Hospital. Comments from the DMA indicate no access problems for Medicaid recipients in the Hospital's primary service areas.

C. The Division of Health Care Quality has determined that the Applicant and any health care facility affiliates have not been found to have engaged in a pattern of practice in violation of the provisions of M.G.L.c.111,s.51(D).

D. The Applicant has agreed, as a condition of approval, to maintain or increase the percentage of gross patient service revenue allocated to free care, as defined at M.G.L.c.118G or its successor statute covering incompensated care, as existed prior to the transfer. The percentage of gross patient service revenue, allocated to free care in FY 2001 at New England Medical Center was 2.11%.

E. The Division of Health Care Quality has confirmed New England Medical Center, Inc. is a licensed facility.

****

The meeting adjourned at 11:20 a.m.

_____
Howard K. Koh, M.D., M.P.H.
Chairman

LMH/lmh